Unexpected Fatality Review

Pierce County Sheriff's Office

2024 Unexpected Fatality Incident # 2427400640

Report to the Legislature

As required by RCW 70.48.510

Date of Critical Incident 9/30/2024

Date of Publication 6/2/2025

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Table of Contents

LEGISLATIVE DIRECTIVE PER ESSB 5119 (2021)

A city or county department of corrections or chief law enforcement officer responsible for the operation of a jail must conduct an unexpected fatality review when a person confined in the jail dies unexpectedly.

The city or county department of corrections or chief law enforcement officer must issue a report on the results of the review within 120 days of the fatality, unless an extension has been granted by the chief executive, or if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the Legislature.

The Department of Health must create a public website where reports must be posted and maintained. Reports are subject to public disclosure and confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with applicable state and federal laws. No provision of this act may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

Unexpected fatality review is defined as a review of any death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated and includes the death of any person under the care and custody of the city or county department of corrections or chief local enforcement officer, regardless of where the death actually occurred. A review must include an analysis of the root cause or causes of the expected fatality, and an associated corrective action plan for the jail to address identified root causes and recommendations made by the unexpected fatality review team.

DISCLOSURE OF INFORMATION RCW 70.48.510

(1)(d) Upon conclusion of an unexpected fatality review required pursuant to this section, the city or county department of corrections or chief law enforcement officer shall, within 120 days following the fatality, issue a report on the results of the review, unless an extension has been granted by the chief executive or, if appropriate, the county legislative authority of the governing unit with primary responsibility for the operation of the jail. Reports must be distributed to the governing unit with primary responsibility for the operation of the jail and appropriate committees of the legislature, and the department of health shall create a public website where all unexpected fatality review reports required under this section must be posted and maintained.

An unexpected fatality review report completed pursuant to this section is subject to public disclosure and must be posted on the department of health public website, except that confidential information may be redacted by the city or county department of corrections or chief law enforcement officer consistent with the requirements of applicable state and federal laws.

(2)(4) No provision of this section may be interpreted to require a jail to disclose any information in a report that would, as determined by the jail, reveal security information about the jail.

UFR COMMITTEE MEETING INFORMATION (CRITICAL INCIDENT REVIEW)

Meeting date: 10/23/2024

COMMITTEE MEMBERS IN ATTENDANCE

Facilitator / Coordinator		
Leslie Medved	(Former) Assistant to the Chief	Corrections Bureau
Medical / Mental Health Team		
Dr. Miguel Balderrama	Medical Director	Corrections Bureau
Karen Bier	Mental Health Manager	Corrections Bureau
Jon Slothower	Health Services Administrator	Naphcare
Angela Valencia	RN, Director of Nursing	Naphcare
Rose Raines	(Former) RN	Naphcare
Lena Leon	ARNP	Naphcare
Command Staff		
Kevin Roberts	(Former) Chief	Corrections Bureau
Steve Jones	(Former) Major	Corrections Bureau
Brian Sutherlin	(Former) Captain	Corrections Bureau
Matthew Dobson	(Former) Captain	Corrections Bureau
Operations Leadership		
Michele Graham	Clinic Liaison Lieutenant	Corrections Bureau
Stacie Woodley	Facility Lieutenant	Corrections Bureau
Glen Davis	Facility Sergeant	Corrections Bureau
Steve Buchanan	Classifications Sergeant	Corrections Bureau
Operations Deputies		
Drajuan Haynes	Corrections Deputy	Corrections Bureau
Chandra Bundy	Corrections Deputy	Corrections Bureau
Donavan Vadala	Corrections Deputy	Corrections Bureau
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FATALITY SUMMARY

AGE: 35 YEARS OLD

DATE OF INCARCERATION: 9/29/2024

DATE OF DEATH: 9/30/2024

The deceased individual was a 35-year old female who was booked in the Pierce County Jail by the Pierce County Sheriff's Department at 00:20 hours on September 29, 2024. The defendant was booked on the charges of Violation of a Protection Order/Domestic Violence. On September 30, 2024, the deceased was found unresponsive in her cell by custody staff.

INCIDENT OVERVIEW

On 9/30/24, at approximately 0915 we began serving lunch in 5 West A unit. The Unit Deputy went into the unit to retrieve lunch trays and when she unlocked 5WA18 for the defendant's cell, she was on the floor and did not respond so the Unit Deputy went into the cell to check on her. She spoke louder and shook her, but she did not respond. The Unit Deputy rolled her over and called a medical emergency on the radio. The Unit Deputy immediately started chest compressions and tapping on her face with an open hand, trying to her to respond and telling another Unit Deputy to get the Narcan. The other Unit Deputy ran and retrieved two of the Narcan. The first dose of Narcan was administered by that Unit Deputy in the defendant's right nostril, which did not have an effect. The defendant had a small amount of blood in her nose. The Unit Deputy then administered the second dose of Narcan in the left nostril. Chest compressions continued by multiple Corrections Deputies. Nursing staff arrived and the Corrections Deputies were told to stop compressions and to cut the defendant's shirt so they could administer the defibrillator. Medical Staff applied the defibrillator pads, AED advised "no shock" (2-3 times). Tacoma Fire Department arrived and took over CPR. At 0952 Tacoma Fire pronounced the defendant deceased and CPR was discontinued.

The PCSD Investigations Bureau On-Call Detective was notified of the in-custody death at approximately 0954. The On-Call Detective contacted the Jail Shift Commander at 0956. The ambulance departed at 1002. Tacoma Fire Department departed at 1004. The other On-Call Detective called at 1018. The On-Call Detective and Forensics arrived on site at 1039. The Chief of Investigations arrived on site at 1126. Medical Examiner arrived on site at 1126. Medical Examiner and Forensics departed with deceased at 1201.

COMMITTEE DISCUSSION

THE SCOPE OF REVIEW INCLUDED:

- Defendants complete booking file
- Defendants current and historical jail medical records
- Facility logs related to the defendant and/or incident
- All internal reports and noted related to the incident
- Detectives investigative report
- Medical Examiner's report and autopsy results

THE POTENTIAL FACTORS REVIEWED INCLUDE:

A. Structural
    a. Risk factors present in design or environment
    b. Broken or altered fixtures or furnishings

B. Clinical
    a. Relevant decedent health issues/history
    b. Interactions with Jail Health Services (JHS)
    c. Relevant root cause analysis and/or corrective action
    d. After action response

C. Operational
    a. Supervision (e.g., security checks, kite requests)
    b. Classification and housing
    c. Staffing levels
    d. Known self-harm statements
    e. Review of inmate communications (phone calls/video visits)
    f. Life saving measures taken
    g. Training recommendations

COMMITTEE FINDINGS

The committee found the overall response and handling of this unfortunate incident resulting in the loss of life was both appropriate and professional. All the tools and resources available were utilized in the efforts to preserve the life of this individual.

STRUCTURAL FINDINGS

The incident took place in a single-occupant cell on the 5th floor of the Pierce County Jail. The cell had adequate lighting from the cell window, which was not covered, as well as from the ceiling light. All fixtures in this housing cell, including the emergency call button, were functional.

COMMITTEE FINDINGS – CLINICAL

At the time of the incident, this individual was housed in the female intake unit. This individual was under the care of Jail Health Services (JHS) for detox protocols. Postmortem Examination Report shows Acute fentanyl and methamphetamine toxicity; Hypertensive cardiovascular disease and mild aortic atherosclerosis. As far as the actions in response to the Medical Emergency, the JHS team did not identify issues or failure to follow policies/procedures, training, supervision or management, personnel, culture or other variables.

COMMITTEE FINDINGS – OPERATIONS

The area of this incident was fully staffed. It is reported all responding PCSD Corrections Bureau staff acted within policy. Uniformed PCSD Corrections Deputies immediately began CPR and continued its application until relieved first by Naphcare Medical Staff, then by Tacoma Fire Department medics. Review of unit logs for this housing unit was completed, and it shows welfare and security checks were done in accordance with policy.

COMMITTEE RECOMMENDATIONS

As with all reviews of critical incidents in our facility, the following requests/recommendations were made in effort to strengthen measures to maintain a safe, secure, and constitutional facility. Although we have a contract for 24/7 on-sight Jail Health Services, some of our custody staff are asking for additional CPR/1st Aid Training. ACTION: CPR Training is scheduled for 2025 for all Jail Staff. As the opiate crisis is felt across the nation, our medical team is seeing a pattern of patients coming to the facility with history of Fentanyl addiction. Fentanyl withdrawals are seemingly worse than withdrawals from heroin. ACTION: We have provided training and issued Narcan to all staff members on our Bureau.